STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING _____ B. WING _____	C 07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD HEALTH CAMPUS	**2494 N LEBANON ST LEBANON, IN 46052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of Complaint IN00147237.

Complaint IN00147237 Unsubstantiated, due to lack of evidence.

Survey date: July 17, 2014

Facility number: 002703
Provider number: 155680
AIM number: 200309250

Survey team:
Maria Pantaleo, RN,TC
Rita Mullen, RN
Bobette Messman, RN
Holly duckworth, RN

Census bed type:
SNF: 13
SNF/NF: 36
Residential: 28
Total: 77

Census payor type:
Medicare: 13
Medicaid: 25
Private: 39
Total: 77

Sample: 4

Homewood Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00147237.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review 07/18/14 by Lisa McColly	F 000		